louisiana healthcare connections

Medical Record Review Scorecard

Responses: Met = 1, Needs Improvement = 0.5, Not Met = 0, Not Applicable = NA

STANDARD #	POINTS POSSIBLE	STANDARD DESCRIPTION	Notes
1.	1	The record is legible to someone other than the writer	
2.	1	All records are safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all enrollees evaluated or treated, and is accessible for review and audit	
3.	1	Each page in the record contains the patient's name or ID number	
4.	1	The medical record includes the identifying information, including name, identification number, date of birth, sex, legal guardianship (if applicable)	
5.	1	Primary language spoken by the enrollee and any translation needs (if any) are documented	
6.	1	The medical record includes services provided, date of service, service site, and name of service provider	
7.	1	The medical record includes past medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed	
8.	1	If PCP is the referring physician, and consultation is requested, there is a note of the referral being made to the consultant including follow-up and outcome of the referrals in the record.	
9.	1	The medical record includes signed and dated consent forms (as applicable)	
10.	1	The medical record includes emergency and/or after-hours encounters and follow-up care (as applicable)	
11.	1	Documentation of immunization status in the medical record for adults (21 years of age or older)	
12.	1	Documentation of Advanced Directives in the medical record (as appropriate)	
13.	1	Documentation of each visit in the record includes date and begin and end times of service	
14.	1	Documentation of each visit in the record includes chief complaint or purpose of the visit	
15.	1	Documentation of each visit in the record includes diagnoses or medical impression	
16.	1	Documentation of each visit in the record includes objective findings	
17.	1	Documentation of each visit in the record includes patient assessment findings	
18.	1	Documentation of each visit in the record includes studies ordered and results of those studies (as applicable)	
19.	1	Documentation of each visit in the record includes medications prescribed (if applicable)	
20.	1	The medical record includes health education provided	

21.	1	All entries contain the name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider	
22.	1	Initials of providers are identified with correlating signatures	
23.	1	Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.	
24.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 0-20 years): Comprehensive health history and physical exam	
25.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 0-20 years): Appropriate immunizations	
26.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 0-20 years): Appropriate lab testing	
27.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 6 months-6 years): Lead Screening. If patient blood lead test result of >5 ug/d, did provider report the case to the Office of Public Health's Childhood Lead Poisoning Prevention Program within 24 working hours?	
28.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 0-20 years): Health Education (including anticipatory guidance)	
29.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 24 months-20 years): Body Mass Index (BMI)	
30.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 0-20 years): Vision Screening	
31.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 0-20 years): Hearing Screening	
32.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 6 months-6 years): Oral Health Risk Assessment	
33.	1	The record includes the following EPSDT specific requirements and periodicity schedule* (age range 9 months-30 months): Developmental Screening. If patient screens positive, was the patient referred for further evaluation?	
34.	1	The record includes the following EPSDT specific requirements (age range 18 months-24 months): Autism Screening. If patient screens positive, was the patient referred for further evaluation?	
35.	1	The record includes the following EPSDT specific requirements (age range 11 years-20 years): Appropriate notation in the record assessing the use of tobacco, alcohol, and substances. If tobacco use noted, was nicotine cessation offered (counseling, hypnosis, medications, referral)?	
36.	1	The record includes the following EPSDT specific requirements (age range 12 years-20 years): Appropriate screenings for depression and suicide risks. If patient screens positive, was the patient referred for further evaluation?	

*EPSDT Reference: Bright Futures/AAP (American Academy of Pediatrics) Periodicity Schedule

Clinical Practice Guidelines (CPG) Measures

Scoring: Met / Not Met / Not Applicable (NA)

Controlling Blood Pressure	Score
For patients with a diagnosis of hypertension, is there documentation that the provider discussed lifestyle interventions with the patient at every visit (i.e. weight loss, the DASH {Dietary Approaches to Stop Hypertension} diet, sodium reduction, potassium supplementation, increased physical activity, smoking cessation, reduction in alcohol consumption, etc.)?	
For patients with a diagnosis of hypertension and prescribed blood pressure medication, is there documentation that the provider inquired about the adherence of medication with each follow up visit?	
For patients with a diagnosis of hypertension and with or without prescribed blood pressure medication, if the blood pressure taken in the office is normal (<120 mm Hg and <80 mm Hg, was a 1-year follow-up appointment recommended? If the B/P taken in the office is elevated (130-139 mm Hg SBP/ 80-89 mm Hg DBP) was a 3–6-month follow-up appointment recommended?	

**2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (Volume 71, No. 19, 2018) Journal of the American College of Cardiology*

Diabetes Type 2	Score
For patients with a diagnosis of diabetes, was an HbA1c (A1c) ordered at least annually?	
For patients with a diagnosis of diabetes, was education provided on lifestyle modifications (i.e. medical nutrition therapy and healthy eating patterns, regular and adequate physical activity, sufficient amount of sleep, behavioral support, and smoking cessation with avoidance of all tobacco products)?	
For patients with a diagnosis of diabetes, was a kidney health and lipid screening ordered at least annually (Lipid profile, eGFR {estimated glomerular filtration rate} and UACR {spot urine albumin-to-creatinine ratio})?	

**Standards of Care in Diabetes (Volume 48 Issue Supplement 1 December 2024) American Diabetes Association*

**Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm (Volume 26, No.1, January 2020) American Association of Clinical Endocrinologists and American College of Endocrinology*

ADHD Diagnosis (Focused Review) for Ages 6-12 Years	Score
For patients with a diagnosis of ADHD, did the provider recommend a follow-up visit with a practitioner with prescribing authority within 30 days (Initiation Phase) of the initial prescription of an ADHD medication?	
For patients who remain on ADHD medication for at least 210 days, were at least two follow-up visits with a practitioner with prescribing authority recommended in the 9 months (day 31-300) after the Initiation Phase? ** *Only one of the two visits may be an e-visit or virtual check-in.*	
For patients with a diagnosis of ADHD and prescribed ADHD medication, did the provider document an evaluation of side effects with each visit (i.e. appetite suppression, growth retardation, tachycardia and rise in blood pressure, orthostatic hypotension, insomnia, sedation, tics, mania/psychosis, seizures, suicidal behavior, mood lability and aggression, hepatotoxicity)?	

** Clinical Practice Guidelines for the Assessment and Management of Attention-Deficit/Hyperactivity Disorder (Volume 144, Issue 4, October 2019) American Academy of Pediatrics*

**Follow-Up Care for Children Prescribed ADHD Medication (ADD) -HEDIS MY 2024*

Louisiana Healthcare Connections Complete List of Clinical Practice Guidelines can be found on the website at:
https://www.louisianahealthconnect.com/providers/quality-improvement/practice-guidelines.html